

YOUR FAMILY DENTIST, PC

DR. YATI YADAV, DDS, FAGD & ASSOCIATES

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PATIENT INFORMATION

Please complete the following confidential information

Patient's Name Last _____ First _____ MI _____

Home Phone (_____) _____ Work (_____) _____ ext _____ Cell (____) _____

Other# (_____) _____ E-mail _____ Marital Status: S M D W

Mailing Address: Street _____ City _____ State _____ Zip _____

M__ F__ Date of Birth ___/___/___ Driver's License # _____ Social Security# _____

Patient's Employer _____ Employer Address _____

Spouse's Name _____ Spouse's Employer _____

ADDITIONAL INFORMATION

Who may we thank for referring you? _____

Emergency Contact _____ Phone (____) _____

Closest Relative _____ (____) _____
(Not living with you) Name Address Phone

Physician _____ (____) _____
Name Address Phone

INSURANCE INFORMATION

Insurance policies are contracts between you and your insurance company. We are happy to assist you with your claim forms and your efforts to get appropriate coverage. To avoid misunderstandings regarding health insurances, our professional services are charged directly to you, and you are personally responsible for payment of fees.

Primary Insurance Policy

Insurance Company _____ Insured's Name _____

Insurance Address _____

Insurance Co. Phone (____) _____ Employer _____

Insured's SS# _____ Insured's Date of Birth: ___/___/___ Group# _____

Secondary Insurance Policy

Insurance Company _____ Insured's Name _____

Insurance Address _____

Insurance Co. Phone (____) _____ Employer _____

Insured's SS# _____ Insured's Date of Birth ___/___/___ Group# _____

Signature of Patient/Insured: _____ Date: ___/___/___

Please sign here to verify the above information is correct.